

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36646

Registration District No. 209 Primary Registration District No. 3043 STATE FILE NUMBER 418 Registrar's No.

1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Palmyra		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth		Length of stay in 1b 10/16/57		d. STREET ADDRESS (If outside, give location) Rural Route # 2		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAUDE				4. DATE OF DEATH Month October Day 20 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1877 April 4, 1877	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Clarence Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Sumner				14. MOTHER'S MAIDEN NAME Nellie Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address James M. Powell Palmyra Missouri			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from October 19, 1957 and last saw her alive on Oct 19, 1957 Death occurred at 5:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) [Signature]				22b. ADDRESS [Signature]		22c. DATE SIGNED Oct 22/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/22/57		23c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park		23d. LOCATION (City, town, or county) (State) Hannibal Missouri	
24. JUDICIAL DISTRICT [Signature]		25. DATE RECD. BY LOCAL REG. 10-24-57		26. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED OCT 30 1957
MARION CO. HEALTH DEPT.
DATE FILED OCT 30 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
John S. Stand

Licensed Embalmer No.....45

P. O. Address.....Hannibal Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.